DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145239	A. BUILDING ______ B. WING ______	C 11/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE REHAB & HC	**5533 NORTH GALENA ROAD PEORIA HEIGHTS, IL 61614**

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F 000	INITIAL COMMENTS complaint 1424945/IL72988 F225/F226 complaint 1424972/IL73014 no deficiencies	F 000		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the	F 225		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE   TITLE   (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to investigate an allegation of abuse and protect a resident during an investigation of an allegation of abuse. This failure affects six of nine residents (R2, R3, R6, R7, R8 and R9) reviewed for a abuse in a sample of nine and 11 residents (R10-R20 in the supplemental sample.

Findings Include:

On 11/5/14 at 12:00 P.M., E14 (Certified Nursing Assistant) CNA stated, "Around 7:00 to 8:00 o'clock (R2) was in (R2)'s wheelchair going down the hallway. E17 (CNA) came up the hall with (R2), pushing (R2) real fast. The medication cart was in the hallway. I heard E17 say, 'No (R2)' and saw (E17) grab (R2)'s wheelchair and push (R2) into the med cart. (R2) started crying. I calmed (R2) down a little bit and I asked E17 why did she do that? (E17) didn't answer me. We were working short (of staff) that night and (E17) had a lot of lights going off on her hall. I reported it to (E16) (Licensed Practical Nurse) right away. (E16) said something to (E17) and then she called (E12)."

On 11/5/14 at 12:10 P.M., E12 (Licensed Practical Nurse) stated, " I received a call from the facility in the evening (11/2/14) concerning (R2). (E16) (Licensed Practical Nurse) called and said 'I just want to give you a heads up concerning (R2). I witnessed a CNA, (E17) push

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(R2) into a med cart.' I told (E16) to monitor (R2) for bruising. I said I would notify the (Director of Nursing) DON. The DON (E2) didn't answer, so I texted her. I didn't call anyone else. I did not send (E17) home that night."

On 11/5/14 at 1:45 P.M., E15 (CNA) stated, " At the beginning of second shift on (11/2/14), it was real short (staffed). E17 was sent to the East Hall, (E17) was very unhappy about it. During supper, me and (E17) were in the dining room and (E17) was standing next to a lady that started vomiting. (E17) had to clean it up, (E17) was very unhappy about it. Around 7:00 (o'clock), I was at the desk with (E14) and saw (E17) going down the hall with (R2) in (R2)'s wheelchair. (E17) pushed (R2) intentionally right into the med cart. (R2) started crying. I went and got (E16) and (E16) asked (R2) if (E17) shoved (R2) into the cart and (R2) said yes. (E16) called (E12) and said 'I didn't send (E17) home because we are too short-staffed."

On 11/5/14 at 1:58 P.M., E16 (Licensed Practical Nurse) LPN stated, " Around 7:00 o'clock (11/2/14), E15 came to me and told me (E17) pushed (R2) into my medication cart. (E17) normally works NW hall and was floated to East hall. You could tell (E17) was not happy about it. I reported it to (E12) later that night. (E17) finished (E17)'s shift and punched out at 10:00 o'clock. I did not send (E17) home that night, I was told not to send anybody home without getting the okay from the higher ups. I did not call the Administrator. (E12) said she would take care of it."

On 11/5/14 at 1:35 P.M., (E17) (Certified Nursing Assistant) CNA stated, "Usually I work NW hall, I got pulled to East (Hall) (11/2/14). There were five

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CNAs Sunday, usually there are 6-7. We were laying people down. I was working with a CNA (E15) that got mandated to stay over. We were also giving showers. (R2) kept coming on our hall and kept going into our rooms. They (E15 and E16) were just sitting at the desk. They said don't push (R2) down that hall, but I did it anyway. (R2) was in our way. The medicine cart was there, but I don't remember (R2) hitting the cart."

On 11/5/14 at 11:45 A.M., E2 (Director of Nurses) DON stated, " I was notified via text on 11/2/14 at 7:30 P.M., but I did not read the text until the next day. I started my investigation the next day when we talked about it at staffing (meeting)."

On 11/5/14 at 11:50 A.M., E2 (Administrator) stated, " I was not notified about the incident (concerning R2) the evening it happened. We talked about it the next morning at staffing."

R2's current Physician Order Sheet (POS) dated November 2014 includes the following diagnoses: Alzheimer's Disease and Blindness in the Right Eye.

R2's current care plan dated 6/27/2013 documents impaired cognition, repetitive verbalization and wandering behavior.

R2's nurses notes indicate no documentation for the incident that occurred on 11/02/14.

On 11/03/14 R17 continued to work the remainder of her shift and provide care for 17 residents (R2, R3, R6, R7 through R20) on the East hall.

The facility policy titled "Abuse Prevention

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F 225	Continued From page 4 Program Policy" directs staff, "Employees are required to immediately report any occurrences of potential/alleged mistreatment, neglect, and abuse of residents and misappropriation of resident property they observe, hear about, or suspect to a supervisor and the administrator." The policy further directs staff, "Employees of this facility who have been accused of mistreatment, neglect, abuse or misappropriation of resident property will be immediately removed from resident contact until the results of the investigation have been reviewed by the administrator or designee."	F 225		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to follow their policy for investigating an allegation of abuse, and protecting a resident during an investigation of abuse. This failure affects six of nine residents (R2, R3, R6, R7, R8 and R9) reviewed for a abuse in a sample of nine and 11 residents (R10-R20) in the supplemental sample. FINDINGS INCLUDE: On 11/5/14 at 12:00 P.M., E14 (Certified Nursing Assistant) CNA stated, "Around 7:00 to 8:00	F 226		

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F 226	Continued From page 5 o'clock (R2) was in (R2)'s wheelchair going down the hallway. E17 (CNA) came up the hall with (R2), pushing (R2) real fast. The medication cart was in the hallway. I heard E17 say, 'No (R2)' and saw (E17) grab (R2)'s wheelchair and push (R2) into the med cart. (R2) started crying. I calmed (R2) down a little bit and I asked E17 why did she do that? (E17) didn't answer me. We were working short (of staff) that night and (E17) had a lot of lights going off on her hall. I reported it to (E16) (Licensed Practical Nurse) right away. (E16) said something to (E17) and then she called (E12)." On 11/5/14 at 12:10 P.M., E12 (Licensed Practical Nurse) stated, " I received a call from the facility in the evening (11/2/14) concerning (R2). (E16) (Licensed Practical Nurse) called and said 'I just want to give you a heads up concerning (R2). I witnessed a CNA, (E17) push (R2) into a med cart.' I told (E16) to monitor (R2) for bruising. I said I would notify the (Director of Nursing) DON. The DON (E2) didn't answer, so I texted her. I didn't call anyone else. I did not send (E17) home that night." On 11/5/14 at 11:45 A.M., E2 (Director of Nurses) DON stated, " I was notified via text on 11/2/14 at 7:30 P.M., but I did not read the text until the next day. I started my investigation the next day when we talked about it at staffing (meeting)." On 11/5/14 at 11:50 A.M., E2 (Administrator) stated, " I was not notified about the incident (concerning R2) the evening it happened. We talked about it the next morning at staffing." On 11/03/14, R17 continued to work the	F 226		

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F 226	Continued From page 6 remainder of her shift and provide care for 17 residents (R2, R3, R6, R7 through R20) on the East hall. The facility policy titled "Abuse Prevention Program Policy" directs staff, "Employees are required to immediately report any occurrences of potential/alleged mistreatment, neglect, and abuse of residents and misappropriation of resident property they observe, hear about, or suspect to a supervisor and the administrator." The policy further directs staff, "Employees of this facility who have been accused of mistreatment, neglect, abuse or misappropriation of resident property will be immediately removed from resident contact until the results of the investigation have been reviewed by the administrator or designee."	F 226		